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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION
Case 01-4319-CIV-KING

SYLVIA ALLEN,
Plaintiff,
vs. MIAMI, FLORIDA
R.J REYNOLDS TOBACCO COMPANY, FEBRUARY 25, 2003
and PHILIP MORRIS INCORPORATED, TUESDAY - 9:00 A.M.
Defendants. MORNING SESSION

TRANSCRIPT OF JURY TRIAL PROCEEDINGS
BEFORE THE HONORABLE JAMES LAWRENCE KING,
UNITED STATES DISTRICT JUDGE
VOLUME 1A

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MORNING SESSION

THE COURT: Thank you. It has been brought to my attention that we had talked about having a charge conference this afternoon. Let me inquire as to the status of the defense case at this point. I don't wish to interrupt it if you have a doctor here from out of town or out of country.

MR. REID: I think we can finish the witness and then have the charge conference late this afternoon, and we are working with Mr. Perwin as we said we would.

THE COURT: About what time do you feel is appropriate to have the charge conference?

MR. REILLY: Your Honor, I don't know exactly how long cross-examination of this witness will take. My direct of the next witness will probably take an hour, maybe a little longer.

THE COURT: So we are looking at 3:00 or 4:00 or 5:00 or something? I hate to start the charge conference at 5:00.

MR. REID: 3:00.

MR. REILLY: Well, I don't want to hold the witness over for another day for the charge conference. I don't think it should take that long to put the witness on, so 3:30, 4:00, so I would think that's highly probable.

MR. COHEN: Our expectation, Judge, is that we would be able to meet that time frame, 3:30, 4:00, charge conference.

MR. REID: I will have somebody call Joel.

THE COURT: All right. Also let me announce that with

respect to the motions for directed verdict that have been

made, Rule 50 motions, at the conclusion of the plaintiff's case, that I have reviewed a great number, perhaps most if not all, of the cases that have been referred to me and I have reviewed my notes on your argument. I have concluded that sufficient evidence has been presented to submit this matter to the jury. The motions are denied.

I reviewed and considered last night the motion to strike that was filed by the plaintiff regarding the portion of the testimony of Lacy Ford given February 19, 2003 and the defendant's response thereto, and concluded that that motion should be and is denied.

The parties will only be able to argue to the jury what is a matter of record, not argue confusion or anything. But if that comes up, it would be subject, and I don't think it will, I don't think anybody's going to argue -- I am sure no one's going to argue -- that the confusion that the plaintiff apprehends will be argued to the jury as a matter of fact or a matter of actual status of the record. If it does, we can deal with it at that time and/or it can be argued in rebuttal or a jury instruction can be done at that time.

All right. Bring in the jury.

[The jury returns to the courtroom.]

THE COURT: Thank you. Be seated, please.

Let's see, I believe when we recessed we had Doctor

Manyak. Is he available?

Would you please step up. We have reached the point that we are about to commence cross-examination. Doctor, you are reminded that you are under oath.

Mr. Cohen for the plaintiff.

CROSS EXAMINATION

BY MR. COHEN:

Q. Doctor, I am Jay Cohen. I represent Sylvia Allen.

Doctor, yesterday you talked a little bit with the jury about the spread of cancer and the pattern of disease. Do you recall that?

A. Yes, sir.

Q. What you told the jury was about how a kidney cancer can spread to other organs and other systems of the body through the lymphatic system, the drainage system as you described it, or the blood system, correct?

A. Yes, sir.

Q. Is the opposite also true?

A. What do you mean by that?

Q. Can cancers of other organs spread through the lymphatic system and through the blood system to the kidney?

A. Yes.

Q. So a lung cancer, if it's primary, can spread from the lung via one of those two routes and attack the kidney?

A. Yes.

Q. Can a lung cancer spread via one of those two routes and attack the other bones of the body?

A. Well, it would be primarily through the blood route to go through the bones as it would be with other cancers.

Q. So, for example, you are familiar with the spread of lung cancer to the spine?

A. I don't study or deal with lung cancer on a routine basis, but in general, yes, I am familiar with that concept.

Q. It can spread to the skull?

A. It can.

Q. It can spread to the liver?
A. It can.
Q. To the kidney?
A. It can.
Q. That's what we have been calling metastatic spread?
A. A spread from a primary site to a secondary site is metastatic spread.
Q. Can a cancer in an organ spread within itself in that organ?
A. It can on occasion, depending on the organ system. That is thought to be possible in certain organ systems. It depends. The question in many pathological circles is whether or not there is internal spread or whether there are secondary primaries that arise. That's a matter of debate as far as my understanding of pathological process is concerned.

Q. That's an interesting concept that you just talked about and I was going to ask you.
What is a second primary site? What does that mean in cancer?
A. It means there is a second site with another cancer that arises there.
Q. So there is even occasions in which there can be a primary cancer in one organ and then a second primary cancer in another organ?
A. It's very rare, but it can happen, yes.
Q. Have you ever heard of the axiom "there are no rules concerning cancer?"
A. I am not sure that I would abide by that. There are certainly many rules about cancer. In fact, the definition of cancer follows a set of rules.
I think that many things can happen with cancer, if that's the point you are trying to make.
Q. Do you know a Doctor Steven De Prima?
A. I do not.
Q. Do you know a radiologist who was called by the defendant cigarette companies in this case?
A. I don't know any of those radiologists.
Q. Did you read any trial testimony?
A. I believe I read Doctor Nadji's testimony.
Q. You read Doctor Nadji's trial testimony from this case?

A. Yes, yes.
Q. Did you ask for that?
A. No.
Q. It was provided to you?
A. Yes.
Q. By the lawyers representing the cigarette companies?
A. Yes.
Q. Do you know why?
A. Well, I presume that they wanted me to read the testimony to see what the comments were regarding his particular area of testimony.
Q. Did you need that?
A. I don't know. It didn't change my opinions at all. So I certainly didn't need it. But when you are in these situations and people ask you to read things, you generally read them.
Q. But you didn't ask for it?
A. No, I did not.
Q. Did you read any other trial testimony?
A. I don't believe so, sir.

Q. Were you told about any of the trial testimony that has gone on in this case?
A. Not really. Maybe a comment here or there, but no substantive discussion about what's going on here.
Q. You came into town when, Doctor Manyak?
A. Sunday night.

Q. Had a chance to meet with the lawyers for the cigarette companies that hired you?
A. I met with them briefly, yes.
Q. Is that when Doctor Nadji's trial testimony was given to you?
A. No, it was sent to me I think about two days before that.
Q. So while you were still in your hometown?
A. Yes.
Q. Doctor Manyak, one of the reasons you gave this jury yesterday was that you thought that this was a renal cell carcinoma was due to some of the treatment that Mr. Allen received in his last hospitalization, correct?
A. That's one piece of evidence, yes.
Q. You would agree that what you were talking to him about was the IL-2 treatment, or the IL-2 course of treatment, that Mr. Allen was given in that last hospitalization?
A. Yes, that was the component therapy that we were talking about.
Q. IL-2 is interleukin-2?
A. Yes.
Q. Today there is even new phases of interleukin, correct?
A. There are several types of interleukin. The protein is involved in a inflammatory cascade. Interleukins have various actions. IL-2 is being looked at for use in cancer, but some of the other ones are as well.

Q. You are certainly familiar with IL-2. As you told the jury, you believe that is an immunotherapy, not a chemotherapy, but an immunotherapy that is used to treat kidney cancers?
A. That actually falls in a category of biological response modifiers. That is, in essence, what an immunotherapy is. It alters or effects the immune system in some fashion.
Q. You told the jury you reviewed the medical charts and records in this case, correct?
A. Yes, sir.
Q. In particular you would have reviewed the last hospitalization, being -- assume with me it's August 24, 1999, until the date of his death, October 1, 1999, correct?
A. I reviewed it originally, yes.
Q. Can we look at some of those records together that you reviewed?
A. Certainly.
Q. I have what is called an Elmo up here.
A. Does this mean I don't need to use my glasses?
Q. I hope that's true, and I can even zoom in it for you.
One of the things that you discussed with the jury yesterday when you were looking at some of his records was the discharge summary. Do you remember that?
A. Yes.
Q. I believe, if I am not mistaken, there was a blowup of that that Mr. Cesarano and you went through, correct?

A. Yes, sir.

Q. Doctor, although you indicated that this was a discharge summary, but it's really an expiration summary. You know that term, correct?
A. I am not familiar with the term "expiration summary." We speak of death certificates and discharge summaries. I am not familiar with expiration summaries, per say, as the term, but I will accept that, whatever you mean by that.
Q. Fair enough. Discharge summary is fine. In any event, this was signed and dictated October 13th of 1999, correct?
A. That's what the date says. I see a date of October 1st here.
Q. That was the expiration date. That means the day he died, correct?
A. Correct. I don't see any other date that tells me when this was dictated.
Q. Let me show you on this page.
A. I see it there, dictated date.
Q. Going back to the first page, you saw, when you reviewed this chart, that at least at the time of his admission, that is when he is admitted by his primary physician, his attending physician, the admitting diagnosis was lung cancer, correct?
A. Yes.
Q. When he died, the death diagnosis was lung cancer, correct?
A. According to this document, yes.

Q. With respect to the history, what you told the jury yesterday was that the reference to a kidney cancer as indicated under history is that in the past it was undecided whether it had originated in the kidneys or the lung, correct?
A. Yes.
Q. So as of the date of this discharge summary, a fair reading of this is that the patient died from a lung cancer that was terminal, correct?
A. It's incorrect, because I believe they missed the diagnosis. They are consistent with their inaccuracy, yes.
Q. They are wrong?
A. Yes, they are.
Q. Let's see what else you told the jury. Getting back to the issue on the interleukin-2, and one of the reasons and one of the bases for your opinion was this course of treatment. Did you look at this record when you reviewed the charts and records of Bob Allen?
A. Yes.
Q. You can certainly know that this is pharmacy orders that are typical in every hospital, orders entered by physicians, correct?
A. It's the type of pharmacy order used by this particular hospital. It varies from hospital to hospital, but essentially it's just another type of form.
Q. You are familiar at least with respect to that form, that

you may have a different form, but these are the type of orders that doctors even like yourself at George Washington University -- by the way, is that a UHS facility?
A. I don't know what you mean by that. You mean is it owned by UHS?
Q. Yes.
A. The hospital is, but the university is not. The university is separate. They work together in the medical center.
Q. In your facility, you may have a different form, but you certainly have orders that you enter where you order the

appropriate drugs or regimen of drugs or therapy for your patients?
A. That's correct.
Q. Would you agree that under number ten that's highlighted here, this is the order for the IL-2?
A. That's what it looks like, yes.
Q. Tell the jury for what period of time the dosage and the duration for this order.
A. The dosage, as listed there, as everybody can see, at so many units, grams, usually given per surface area of the body, it's said to be given over twelve hours, and continues infusion for four days for a total of two liters.
Q. Intended, obviously, for a regimen of four days?
A. That's what it appears to be, yes.
Q. Do you know the duration, the dosage, the appropriate

acceptable regimen for IL-2 therapies in kidney cancer patients?
A. I do not administer chemotherapy or immunotherapy of this type, intervenous. I am familiar from the standpoint of what the variable dosages and length of treatment is for an individual cancer.
I am familiar that it's variable depending on how the patient responds and what their side effects are.
Q. Yesterday, when you were talking with the jury about IL-2 and about treatment modalities for kidney cancer, you don't do that?
A. No, medical oncologists are the ones that administer those drugs. It would be highly unlikely for a urologist to administer interleukin-2.
Q. Are you a kidney cancer specialist?
A. I am a urologic oncologist which deals with kidney cancer, yes. If you know something about the management of cancer, you realize that there are several people involved with the therapy of cancer. The specialty that primarily deals with medical infusion of chemotherapy and things like immunotherapy are the medical oncologists. It's part of a team approach to the management of cancer. They are an integral part as well.
Q. In any event, you do not get involved in the medical oncology for treatment of a kidney cancer?
A. I do not administer the drugs. I am involved in the

decision process with the physicians. Nor would they, in turn, remove the kidney by surgery. That would be my part of the business.
Q. I take it with respect to this entry and Mr. Allen's medical charts and records, do you even know whether or not that is an appropriate and therapeutic treatment regimen for interleukin-2 on a kidney cancer, or a suspected kidney cancer?
A. It is certainly in the range of the type of administration that would be given. But can I tell you what the specific amounts and times are? No I can not. That is not my area of expertise.
Q. Are you familiar with the side effects of interleukin-2?
A. I am.
Q. You know that as a result of the administration of an interleukin-2, some patients can get a dermatitis or rash, correct?
A. They get many side effects from this type of medication.
Q. They could get a mucositis, correct?
A. I believe so.

Q. Do you know what that is?
A. I know what a mucositis is. I honestly don't know if they can or not get a mucositis, to be honest with you. What they get is a syndrome, like a shock-like syndrome, where you have a multiple of things that go on. High fevers, vascular -- the integrity of the vessels is changed so that fluid leaks across

the veins and vessels. Fluid fills up lungs. There are problems with cardiac output in blood volume to circulate, and a variety of things like that. In that respect, I know what IL-2 does.

As far as each specific side effect in the percentage of occurrences that occur, I am not -- I am not comfortable with trying to discuss that part.

Q. At the very least, you know that there are possible side effects including skin manifestations?
A. I am sure there might be, certainly. I am familiar with the shock-like syndrome. I have seen it personally in patients when I was at the National Cancer Institute. But I am not familiar with all the myriad side effects that can occur with this systemic medication
Q. When you were looking at Mr. Allen's last admission at the Sylvester Cancer Center Hospital, did you see on this record, the day after the administration, or I should say the order for administering interleukin-2, that there were some other entries concerning that medication?
A. I am sure I read this at one time, yes.
Q. On the top part, on August 28, the day after the record we just saw, there was some verification needed concerning his interleukin-2 dose, right?
A. Well, that's what has been ordered. I don't know what that entails exactly.

Q. You see on the bottom, "8/29/1999?"
A. Yes.
Q. Did you see that entry?
A. I did at one time, yes.
Q. All right. So you acknowledge that by the next day, that is, on the 29th, there was a concern about some reaction that Bob Allen was getting to the interleukin-2, correct?
A. Yes.
Q. There was a record entry by Bob Allen's doctors concerning decreasing the IL-2, and if he continued to have itching symptoms or other symptoms, it was to be discontinued, correct?
A. It's very common with this medication.
Q. What does that mean when a doctor writes that if something continues, it is to be discontinued? What does that mean? What does the discontinuing referring to?
A. That would be to stop the medication.
Q. And you saw this?
A. I saw the order, yes.
Q. Did you see this document, the very next day in the same medical chart and records of Bob Allen that you reviewed?
A. Yes.
Q. So by August 30, the very next day, that IL-2 was stopped, wasn't it?
A. It looks like it was held on August 30, where it says, "continue to hold IL-2, yes.

Q. Where it says "continue to hold IL-2," if they are reading

as a doctor who is familiar with charts and records, that meant it had been held previous to that entry and was continuing to be withheld from administration to the patient?
A. It appears that the day before they stopped it. They made a judgment that day to continue to hold giving the medication, yes.
Q. Later that day, August 30, 1999, you see a record where they were to resume with some infusion, correct?
A. Yes, after the above medications had been given.
Q. Right, and the above medications included were Benadryl, correct?
A. Yes.
Q. He was having this reaction to the IL-2. They were trying to give him some medications. In the interim, they stopped giving him IL-2, correct?
A. For a short period of time, yes, that's what it looks like.
Q. For a short period of time.
Did you see, Doctor, this record. By September 1, 1999, after the IL-2 had been started, stopped, maybe restarted again, did you see by September 1, 1999, that they had stopped giving Bob Allen IL-2, interleukin, for the alleged treatment of his kidney cancer?
A. Yes, but they didn't stop it because of the effectiveness. They stopped it because of the side effects. It's very common

with this medication. It's very, very tough stuff.
Q. Doctor, did you look at the MAR from his hospital records?
A. Could you please tell me what MAR means?
Q. Medication administration record.
A. I am sorry. Ask me the question again.
Q. The medication administration record.
A. What did you ask me about it?
Q. Did you see his MAR, his medication administration record?
A. I probably did. I would have to see it again. If you want me to refer to it, I would be happy to look at it again.
Q. Absolutely, Doctor.
A. Thank you.
Q. If you could, sir, what I have handed in front of you is a package of the MAR, the medication administration record, for Bob Allen for his last admission at the Sylvester Hospital. I have some highlights in there. I have got a couple of tabs. At the very least, if you would, can you tell the jury when it was that Mr. Allen had received his last interleukin dose?
A. Well, do you have a tab that points that out for me?
Q. Yes, sir.
A. That would save me a lot of time. Which tab would that be?
Q. The last tab.
A. All right. It looks like the date on this appears to be 8/30, 8/28.
Q. So when was it, 8/28 or 8/30?

A. Well, I am reading here -- I'm trying to read through the handwritten stuff as well. It's really kind of unclear to me on this record, but it appears that it's ordered to start on 8/28, ordered to stop on 8/31. It appears that he received his last dose on 8/31 because it's initialed here as -- it looks like it's initialed here that he received it sometime on 8/31. I am not sure when exactly.
Q. Can we at least agree that on 8/31 was, at the outset, the last time that on that sheet he would have received any interleukin-2? And I invite you to go through the rest of the

records.
A. That's fine. I will accept that if that's what you are trying to tell me. It appears that you are correct there. That would match with the orders, too, so that would be consistent.
Q. Doctor Manyak, this was a failed IL-2 attempt at treatment, wasn't it?
A. I wouldn't say it was failed. It was stopped for other reasons. It was failed because of side effects. It wasn't failed because of the failure to be effective. It was an aborted full therapeutic regimen.
Q. Did you review this record by Doctor Sridhal on September 13, 1999 when he talked with the family about Bob Allen's progression of his cancer, and he also spoke to them about the failed IL-2 treatment?

A. IL-2 is given in a series of courses. A full IL-2 course, if I understand correctly, would involve more than one series of infusions. Because he had these side effects that were intolerable, I believe that would be the basis for saying there was a failed therapy with IL-2. It doesn't mean it wasn't effective. It means he couldn't continue with it because of the side effects.
Q. He was never able to reach a therapeutic level for IL-2 because the treatment failed as a result of his reactions, and he never received that subsequent course of therapy that you just told the jury about, correct?
A. I am not sure I agree with that. In one sense, it's failed because he didn't get four different regimens on it. In another sense, he did get a full regimen of the first set of infusions. If you were splitting some hairs here, but yes, it was failed because he didn't get all four regimens or how many courses they wanted to give him. Again, that's a very common thing with this medication. I will concede it's failed. I have no problem with that.
Q. At the very least, Doctor, you agree that this failed attempt on IL-2 therapy, therefore, had no affect on reducing the size of his chest lesions, his chest tumors, his metastatic spread, correct?
A. No, I am not so sure I agree with that. As I testified yesterday, when we looked at the CT scan of the chest, at the

very least, while other tumors were growing in the past, these tumors in the chest had stabilized over that time. In the medical oncology circles and in our circles also, stabilized disease suggests some kind of response in the face of something that's rapidly progressive and growing.
I am not so sure. Again, that's many pieces of evidence about renal cell carcinoma. Frankly, it's the one that I least rely on for my comments about the fact that this is a kidney cancer.
Q. I take it, then, you would at least agree that that would be, in the role of prominence, that's the least prominent basis for your opinions?
Frankly, I expect him to fail from IL-2 with kidney cancer. Only about fifteen percent actually have a response. The fact that anything was seen is surprising and actually a sign that there may have been some effect. Frankly, there is nothing very good from chemotherapy or immunotherapy for kidney cancer.
Q. Were you familiar, in looking at the chart and the records

of Bob Allen, about the treatment he had received prior to his last admission when interleukin-2 was administered?
A. I don't recall that he had interleukin-2 administered before this admission.
Q. No, no, I am not asking you before. This first administration of interleukin-2 during this last

hospitalization, are you familiar, did you review other records and note what kind of treatment he received from other doctors for his lung cancer?
A. I know he received chemotherapy. I don't remember which medications those were. Those were a regimen that are used for lung cancer.
Q. Did you know that Doctor Markoe, in your review of records, also provided radiation treatment?
A. Yes.
Q. Doctor, let me turn a little bit to some discussions you had yesterday to the jury about cigarette smoking and kidney cancer.
A. Are we finished with this record here? Would you like to take it back?
Q. Yes. First of all, and before I get into some of the medical literature and research that you told the jury you did with respect to this case, have you ever published anything with respect to cigarette smoking and kidney cancer?
A. No.
Q. Have you ever published anything with respect to cigarette smoking and lung cancer?
A. No.
Q. Have you ever testified before in a court, whether it be this state or any other state, concerning cigarette smoking and kidney or lung cancer?

A. No, I have not.
Q. The majority of your publications or whatever you have done deals with prostate cancer or bladder cancer when dealing with cancer?
A. Most of them, yes. I have I think three publications on unusual kidney cancers that we have published. We do a lot of work with prostate cancer and bladder cancer as well. Those are areas that I published in, yes.
Q. Sir, did I understand yesterday you told the jury that you do not believe there is a causal link between cigarette smoking and kidney cancer?
A. Yes, that's correct. Kidney cancer arises, renal cell carcinoma. We separate the two and we are talking kidney cancer, we have to discuss either a transitional cell and renal cell carcinoma.
Q. We will talk about the difference between renal cell carcinoma and transitional cell in a second. Your practice of urology, is that part of the internal medicine field?
A. No.
Q. Do you consider yourself an internal medicine physician?
A. No.
Q. Are you familiar with publications in internal medicine that deal with cancers of the kidney or kidney disease?
A. When you say internal medical literature, that encompasses a lot of things. There are articles in epidemiology and other

things that I am familiar with, but certainly, I am not

familiar with all the internal medicine literature on renal cell cancer. That's something that they don't often write about.
Q. You have talked a little bit with the jury about some of the research that you looked at and some of the studies that you've done, and/or your own contributions in medical literature. Are you familiar with Harrison's Principles of Internal Medicine?
A. That's a textbook for internal medicine, yes.
Q. Probably in your office?
A. Probably not.
Q. Published in twelve or thirteen languages across the world?
A. Very possibly. It is a well-known internal medical textbook, and one that I used when I was in medical school.
Q. Do you agree, Doctor Manyak, that each year primary carcinoma of the lung affects ninety-nine thousand males and seventy-eight thousand females in the United States?
MR. REILLY: Objection, Your Honor. He hasn't identified him as an authoritative source in his field or in this field.
THE COURT: All right. Do you know, Doctor, approximately how many people in numbers are affected by the disease or diseases that he referred to?
THE WITNESS: With cancer of the lung, it's

approximately one hundred ninety thousand patients a year, from the cancer statistics that are compiled every year.
Approximately, yes. I am not an expert in lung cancer, so, you know.
BY MR. COHEN:
Q. That's why I'm just asking if you know. Do you know that the large majority of lung cancers are caused by carcinogens and tumor promoters ingested via cigarette smoke?
MR. CESARANO: I object. It's beyond the scope of direct. We didn't discuss primary lung cancers in this fashion, and I object.
THE COURT: Well, I think you can introduce those or have them introduced in other phases. Testing his knowledge in the area, he said that he was not a specialist in lung cancer.
BY MR. COHEN:
Q. Let me ask you this, Doctor, were you telling the jury yesterday that this was not a primary lung cancer and instead was a primary renal cancer?
A. Yes, I was.
Q. Isn't some of this information as a cancer doctor important for you to know from a standpoint of what is the incidence of cancers in the human body when trying to determine whether or not it is a primary lung or a primary kidney?
A. One whole piece of -- a whole set of information that we would look at, but I -- as relating to lung cancer, I am not an

expert in that field.
Q. With respect to whether or not this is a primary lung cancer, you would defer, for example, to a board-certified pulmonologist, wouldn't you?
A. Unless the evidence is so overwhelming as it is in this case that it's a renal cell cancer, which is exactly what it is in my opinion.
Q. For you to be able to reach that conclusion, that determination, don't you have to know a little bit about both disease processes?

A. Oh, yes, I do.
Q. So, do you agree that the majority of lung cancers are caused by cigarette smoking?
MR. CESARANO: I object, Your Honor. He is asking specifically about lung cancers, not as they relate to kidneys.
THE COURT: Overruled. Answer the question.
THE WITNESS: I have not studied the literature in depth about the causes and factors of lung cancer. It is one of those things that are mentioned in the general public that smoking causes lung cancer. What is the actual relationship, I do not know that in any depth.
BY MR. COHEN:
Q. Well, let's talk about renal cell carcinoma. Do you agree that renal cell carcinoma accounts for ninety to ninety-five percent of malignant neoplasms arising from the kidney?

MR. REILLY: Same objection, Your Honor. Counsel is reading from a book that has not been identified as an authoritative source by this witness.
THE COURT: Overruled. You may answer the question.
THE WITNESS: I'm aware that renal cell carcinoma accounts for about ninety percent of kidney cancers.
BY MR. COHEN:
Q. Did you agree that environmental factors have been investigated as possible causal factors?
A. Possible. Emphasize possible, yes.
Q. Do you agree that the strongest association with renal cell carcinoma is cigarette smoking, accounting for as many as twenty to thirty percent of cases?
A. No, I don't agree with that.
Q. Doctor, as a urology specialist who deals with diseases, including cancer of the urological system, are you familiar with the American Cancer Society facts and figures 1999?
A. I know that they put out statistics. I don't have those in front of me. Obviously, you are going to bring them to me. Okay.
Q. Yes.
A. This is one source for cancer statistics, and there are several including some that come from the National Cancer Institute --
MR. CESARANO: May I see those?

THE WITNESS: Yes.
BY MR. COHEN:
Q. The one that I handed you happens to be 1999, doesn't it?
A. Yes.
Q. That's the year Bob Allen died, correct?
A. Yes.
Q. Tell the jury, if you would, looking at those statistics from the American Cancer Society, how many lung cancers, new cases of lung cancers, are estimated, according to that study, in the male population.
A. In the male population, according to these numbers here, it states ninety-four thousand.
Q. Now tell the jury, if you would, how many reported deaths are estimated as a result of lung cancers, according to that study.
A. Ninety thousand, estimated for the year 1999.
Q. Now, they also include in that study, don't they, the association of kidney cancer, don't they?
A. Well, there is no association with kidney cancer. They

mention kidney cancer here.
Q. That's what I mean, sir.
A. We have to make sure we understand the terminology.
Q. Absolutely. They mention kidney cancer, don't they?
A. They do.
Q. Tell the jury how many reported new cases, according to

those 1999 statistics, were put out by the American Cancer Society for kidney cancer?
A. For kidney and renal pelvis, which includes transitional cell cancers, is thirty thousand.
Q. In the male population?
A. In the male population is seventeen thousand eight hundred in this compilation.
Q. So it's seventeen thousand kidney cancers in the male population compared to ninety thousand in lung?
A. Yes.
Q. How many deaths are there associated with kidney cancers in the male population?
A. Seventy-two hundred, less than fifty percent. Less than fifty percent.
Q. Of the reported new cases?
A. Well, yes, but that's a misleading statistic. These are new cancers diagnosed versus people that die of the disease in that year. So they're not one of the same. It doesn't mean that less than half the people die of -- that seventeen thousand have died of cancer that year. That's how many people died that year of kidney cancer.
Q. Can we at least agree that there are seven to eight more cases of lung cancer, new cases of lung cancer, then kidney cancers in the United States?
A. Yes.

Q. Can we also agree that the death rate associated with lung cancer is ten times greater than the death associated with kidney cancer?
A. Sure.
Q. Doctor, one of the things that you had told us you did, or some of the work that you have done, was you did some research and you looked at some studies, correct?
A. Yes.
Q. In that event -- and I should say what you did is you found some articles, some medical literature, some medical research and you relied on them, correct?
A. Well, I used them to get an understanding of the issues that we are talking about in this case, yes.
Q. You relied on them?
A. To some extent, yes. But it wasn't the only source from reliance.
Q. I mean, you gave us a list of the medical research you did and you called it your reliance list.
A. Well, that's a legal term that you use. I would say it's one of the pieces of information I would look at to look at the facts in this case.
Q. By the way, when you do that kind of research, do you charge your time for that?
A. Sometimes, yes.
Q. In this case, you're compensated for --

A. I probably did for this. It took a little time to do this,

yes.
Q. In this case, you are compensated for your time, correct?
A. Yes.
Q. Tell the jury how much you charge an hour for your work, what your initial retainer is, and how much you charge for coming here today and testifying.
A. Sure. The initial review of the case is $1,250. I charge $350 an hour for subsequent work, and $3,000 per half day of court time.
Q. So yesterday you were here, let's say, a half a day?
A. Yes.
Q. And assume you are going to be here another half a day?
A. I hope so.
Q. Because that will be $6,000.
A. Well, I actually lose money coming here from my practice. I get compensated for the time that I'm away.
Q. How many total hours have you put in on this case?
A. Somewhere around forty to fifty hours, I would guess.
Q. Is that at $500 an hour?
A. It comes to $350.
Q. I'm sorry. So how much have you totally earned and charged the lawyers who called you for your work in this case?
A. I haven't submitted the bills. I haven't accepted a preliminary payment. That's unclear. I am not sure. You can

estimate at forty, fifty hours times $350. You can do the math.
Q. So that's about twelve to fifteen thousand right there?
A. Probably, yes.
Q. And then six more thousand for the two days?
A. Yes.
Q. So $20,000 to testify about your opinions?
A. Well, it's an important case to testify in. You know, with these lawsuits that are brought for the wrong reasons --
MR. COHEN: Judge --
THE COURT: Pardon me, Doctor, we have been here four weeks. We don't want to have to do it all over again and have you come back.
THE WITNESS: I am sorry. I apologize if that was out of line. It was not intended to be.
THE COURT: The jury will disregard all that. The jury will decide the merits of the case after considering all the testimony of all the witnesses. The question dealt with the compensation, and it's asked of every witness. They are not picking on you. Both sides, everybody asks the same questions.
All right. I think he has answered the question.
BY MR. COHEN:
Q. Doctor, you talked about the difference between renal cell carcinoma and transitional cell carcinoma, correct?

A. Yes, some of the differences, yes.
Q. The majority of cancers, as we just saw, but even in your own opinion, are renal cell carcinomas?
A. Cancers of the kidney?
Q. Yes, sir.
A. Yes.
Q. Those are called sometimes RCC?
A. That's an abbreviation for renal cell carcinoma, yes.
Q. The majority of renal cell carcinomas, RCC, are clear cell type?

A. Yes, eighty to eighty-five percent.
Q. Not papillary, but clear cell?
A. Clear cell carcinoma, yes.
Q. The other two are the other --
A. Those are other cell types, yes.
Q. -- other cell types of RCC?
A. Well, there are other patterns too. It's just kind of a way that they look at the entire pathological picture and determine it's one type versus another.
Q. The majority of RCCs, almost seventy-five percent, are of the clear cell type?
A. Yes.
Q. So, in the course of your practice, RCC is commonly referred to as clear cell renal --
A. No, actually, we want to know the actual designation

because there are differences with papillary versus clear cell. A papillary, for example, has a much higher familial occurrence. We don't assume it's anything. We like to have a pathological diagnosis.
Q. But in the common use amongst kidney cancer specialists, RCC is commonly referred to as clear cell renal cell carcinoma?
A. No, we are actually very specific about the type. That's precisely my point. We do want to know the cell type. If you were to hazard a guess when somebody tells you they have renal cell carcinoma, then you would guess right three-fourths of the time that it would be clear cell carcinoma. Renal cell carcinoma means all of the renal cell carcinoma.
Q. Which include those three types, the majority being clear cell?
A. Right.
Q. One of the articles that you directed us to, that you relied on, to whatever degree you did, was an article called The International Renal Cell Cancer Study on Tobacco Use. Do you remember that one?
A. I would have to see it again.
Q. Yes, sir.
A. Yes, this is one of the articles that we looked at.
Q. This was one of the articles that not only did you tell us about during your deposition, but you even provided us a copy of, correct?

A. I believe so, yes.
Q. This was a study done by Doctor McLaughlin, right?
A. I, again, would have to see this to agree with -- we will assume that that is the author.
Q. Okay.
A. I mean, I would like to see it. If you want me to answer specific questions, I do want to see what you are referring to.
Q. All right, well, I will tell you what I will do.
MR. COHEN: Judge, may I approach?
THE COURT: Yes.
BY MR. COHEN:
Q. If you don't mind, we will read it together so there's no misunderstanding. This is the study of the -- the International Renal Cell Cancer Study on tobacco use that you referenced us to and you relied on, correct?
A. Yes, that's one of the articles that I supplied.
Q. McLaughlin was one of the principal authors?
A. Yes.
Q. The very first paragraph that is stated in this study is

that, "Cigarette smoking has been found in numerous epidemiological studies to increase the risk of renal cell cancer," correct?
A. That's what it says here, yes.
Q. "A number of case control studies have found dose response relationships among men?"

A. That's what the next sentence says, yes.
Q. Do you agree with that?
A. I think there are other pieces of information here, several other studies where this is unclear. I think that the thing that's consistent with all these studies is we are really not sure what this relationship is. This happens to be one study. For the sake of balance, we -- or I -- want you people to see what we looked at and to see that it is inconsistent.
Q. This study goes on to say that, "Cohort studies of smokers have also reported a link with renal cancer," meaning other studies, correct?
A. That's what he states here, yes.
Q. Do you agree with that?
A. Yeah, sure. There are some that are shown, there are others that have not.
Q. In this report that you supplied us with it says that, "The purpose of this report is to examine in detail the relationship between tobacco use and the risk of renal cell carcinoma using case control data pulled from the centers around the world?"
A. "From six centers around the world."
Q. "Six centers around the world," correct?
A. That's what it says, yes.
Q. Let's look at the -- a conclusion, if you will. All right? "The results of this pooled analysis, the largest study to date" -- and this was published in 1995, correct,

Doctor?
A. Yes.
Q. "The largest study to date, by far, provide convincing evidence that cigarette smoking is a causal, meaning the causes, as a risk factor for RCC, accounting for approximately one out of four cases among men," correct?
A. And one out of ten among women. That's what it says here, yes.
Q. Do you agree with that?
A. As I said, if you take all the information that's out there -- and this is one person's opinion, and the other studies out there are inconclusive as well. I am not sure how much relationship there is.
There appears to be a slight increased risk, which is different than cause, from patients that smoke to develop renal cell carcinoma.
Q. They concluded in the study that you referred us to, that: "In summary, this large-scale population-based pooled analysis of tobacco use and RCC risk confirms cigarette smoking as a causal agent," right?
A. That's what it says here, yes.
Q. "Indicating that elimination of this habit would contribute to a reduction in the number of renal cell carcinoma cases around the world." That's what it concludes?
A. That's what he says. That's his conclusion.

Q. Do you agree?

A. I am not sure about that. As I said, the data from the other studies are very inconclusive to me. I am really not sure, to be honest with you.
Q. You are not sure?
A. I'm really not sure.
Q. You're not sure as to whether or not cigarette smoking is a causal factor --
A. That's not what I said. What I said was I am not sure that if you decrease smoking, it will decrease the amount of renal cell carcinoma. What appears to be the case, is if there is a mild association with an increased risk in patients that smoke to develop renal cell carcinoma. I think that's a fair statement. It's a mild increase. It's at least equal to other factors that are also risk factors for development of renal cell carcinoma as -- I am sorry. Go ahead.
Q. I'm sorry.
THE COURT: Gentlemen, just a moment now while both of you pause, please let each other finish your questions and answers because the court reporter needs to get it down.
THE WITNESS: Sure.
BY MR. COHEN:
Q. Let's look at a couple of the other studies that you referred us to in your reliance list.
One is called Obesity, Hypertension, and the Risk of

Kidney Cancer in Men, correct? You referred that article to us?
A. Yes.
Q. And you did that, you referred that to us, because that was something you relied on, and you talked about with the jury as far as being a risk factor as you believed in developing renal cell carcinoma, correct?
A. Yes, this is one of several studies that were reviewed for this subject.
Q. Now, one of the first paragraphs, or I should say on the first page of this particular study, the authors say, "Obesity increases the risk of renal cell cancer, although this association has not been consistently observed in men," correct?
A. That's what it says.
Q. In fact, you are familiar that a lot of the studies concerning the association of risk factors or causes for renal cell carcinoma differ greatly amongst gender, meaning whether it's male or female, correct?
A. Yes, it's suggested in some studies. It's not consistent in all studies, but it has been suggested in some studies, correct.
Q. They also talked about hypertension. They said, "Hypertension is a risk factor, but quantitative data according to levels of blood pressures are limited," correct?

A. That's what it says, yes.
Q. In this very article about obesity and hypertension and kidney cancer, what do they then say?
A. The next sentence you have highlighted here says, "Cigarette smoking increases the risk of both types of kidney cancer, and the increase is greater for renal pelvis cancer than for renal cell cancer."
Q. And you certainly agree with that?
A. I agree with that, yes.
Q. Let me jump ahead to another article that you referred us

to -- and by the way, with respect to obesity being a risk factor, are you familiar with the fact that the risk factor of that, of being obese, has to do with the longevity of the obesity, correct?
A. I am not sure that has ever been pointed out to a great satisfaction.
Most of the things that I have read don't mention duration of obesity.
Q. Let me show you another study, okay? Risk Factors in Renal Cell Carcinoma, Methodology, Demographics, Tobacco, Beverage Use and Obesity. Do you see that?
A. Yes. This is an article I have not reviewed. This must have come from -- it's dated 1988, so it's a little older.
Q. Let's see what they say, these authors, conclude about their study concerning --

A. I am a little uncomfortable just taking things out of context, of this study, not having read the whole study. I will just say that up front.
Q. Fair enough.
MR. REILLY: Objection, Your Honor. This hasn't been established as an authoritative source.
THE COURT: He says he is not familiar with it.
MR. COHEN: If I can relate him, Judge, to where in this study? What the study relates to is the McLaughlin study that he relied on.
THE COURT: Let's ask him first before you read the article to the jury. Let's find out whether or not he is familiar with it, for starters.
Doctor, did you list this as one of the documents that you relied on?
THE WITNESS: No, I did not, Your Honor.
THE COURT: Are you familiar with this article at all?
THE WITNESS: No, I am not.
THE COURT: I am going to sustain the objection. Let's move on.
BY MR. COHEN:
Q. Let me ask you this, Doctor. Do you agree that for overweight, that is for obesity, to increase the risk of renal cell carcinoma, it must be present in young adult life and maintained throughout the older years?

A. I don't know that. I have never run across that in my review of any literature.
Q. Let's look at, again, one of the articles that you did rely on. The Epidemiology of Renal Cell Carcinoma.
A. Yes, I am familiar with this one.
Q. In this study that you referred us to, it says, "The results of this study was compared with those who never smoked. The odds ratio" -- and tell the jury, what is an odds ratio?
A. An odds ratio is an assessment of what the odds are for somebody to develop something over the general population.
Q. So the odds ratio for renal cell carcinoma among current cigarette smokers was 1.4, which means almost one and a half times the greater risk, correct?
A. That means -- yes. I will accept that.
Q. And that's for men, right?
A. Yes.
Q. And then there was a trend with respect to this study, that is, that risk, that odds ratio risk, increased with the pack years of smoking, correct?

A. Yes, in men.
Q. That's right.
And as you increase the amount of smoking as you increase the years of smoking, there is even a far greater risk of contracting kidney cancer as a result of that dose relationship, right?

A. No. What it says is consistent in several studies. I think that is a trend. If there is a longer smoking history, that there is a higher risk relative to developing kidney cancer. That doesn't mean it causes it. That means that your risk increases somewhat. It increases slightly, actually, if you look at all of the different studies that were provided.
That's why it's important to read several of these studies at the same time so that you can get the picture as to what is consistent and what is not consistent.
Q. So far, can we at least agree that every one of the studies that you referred us to makes the link between cigarette smoking being an associated risk, being a relative risk, and having a causal link as a risk factor to kidney cancer?
A. It has a mild risk association with the development of kidney cancer.
The thing that disturbs me about these kind of studies is it is extremely low for women. You would think that if it's a carcinogenic problem that causes kidney cancer, it would be the same amount in women. I am really unclear what these numbers mean. With a slight increase like that, I am not sure what it means. It's reported and it's there, so we talk about it.
In my own mind, I am really unconvinced that that's a cause for kidney cancer development because I would expect to see that in women as well.

Q. Don't you recognize that some of those studies and some of those authors who recognize the distinction between men and woman, a large part of it is hormonal?
A. A large part of what is hormonal?
Q. The distinction, the difference, as to why whose risk factors are sometimes greater in women as opposed to men, or vice versa with respect to --
THE COURT: Wait a minute. Gentlemen. Repeat your question and finish it, and then we will let him start his answer.
BY MR. COHEN:
Q. I thought what you were indicating, Doctor, was that you are surprised that there's a difference in the relative risk of some agents for causing cancer between men and women?
A. I am referring to specifically kidney cancer.
Q. That's what I mean. You were surprised that there was a difference between men and women and their relative risks for developing kidney cancer from certain known causes?
A. Yes, I am surprised. I would think that a cause for cancer would be indistinct or it should be the same for men and women if it's really a cause for cancer.
Q. As far as some of the risk factors that you discussed with the jury yesterday, the one thing you talked about was also genetics. Do you remember that?
A. Yes.

Q. You don't have any information about Bob Allen's family

history, do you?
A. We have a small amount of information, yes.
Q. Do you know about whether or not his mom, his dad developed kidney cancer?
A. I don't believe they did.
Q. Do you know how old they were when they died?
A. I don't recall that.
Q. Do you recall looking at any history of any medical charts and records that they were in their mid to late 80s when they died?
A. I do not recall that.
Q. In any event, you do not know, and you have no information if Bob Allen's kidney cancer that you think was a primary kidney cancer was as a result of genetics, do you?
A. I think we established that yesterday that it was speculative and the jury was instructed on that matter. So that's absolutely correct. We don't know anything about that further.
Q. Doctor, you talked a little bit about some of the role of a urologist like yourself in dealing with diseases and kidney cancers, and you talked a little bit about pathology. Do you remember that?
A. Yes.
Q. You said you reviewed the pathology of -- at least the

pathology reports on Bob Allen, correct?
A. I reviewed the reports. I did not review the actual slides themselves.
Q. But you are familiar, are you not, Doctor Manyak, that certain immunohistochemical staining can be done on biopsied tissue which can give some very clear and precise information as to cancer, correct?
A. I think stains -- first of all, this is out of my area of expertise. I can't elaborate on various stains. I would defer to the pathologist to determine which stains might be useful to gather the information for the biopsy specimen.
Q. Fair enough. Let me just ask you this question as it relates to your practice. You have never seen a kidney cancer test positive for mucicarmine, have you?
A. Not that I recall.
MR. COHEN: Judge, if I could just have one moment.
THE COURT: Yes, sir.
MR. COHEN: Thank you, Judge. Those are my questions.
THE COURT: Mr. Cesarano.
MR. CESARANO: Thank you, Your Honor. If I could have a second to organize.

REDIRECT EXAMINATION

BY MR. CESARANO:
Q. Doctor Manyak, you were asked a number of questions about the therapy and the treatment that was given to Mr. Allen in

the hospital, and you were referred to this record with respect to the interleukin and the stopping and starting of the interleukin.
I would like to draw your attention to item number 2 up there. What is that? What does that say and what is the significance, please?
A. It is an abbreviation for diagnosis. It says, "Renal cell carcinoma, slash, continuous infusion pretty common at interleukin-2, or IL-2." What that is is a standard notation when a patient is admitted or therapy starts, and not

infrequent to the diagnosis is placed there. That's what the significance of that is.
Q. Now, Doctor Manyak, you were also shown this document. Looking at the highlighted part, down to the next-to-last line, we see, "Patient wants something, Rx." What is that last word there?
A. It looks to me like it might be thalidomide.
Q. Is thalidomide a medication that you are familiar with in your practice?
A. I don't use it in my practice, but I am familiar with it. I think we all heard about thalidomide from thirty or forty years ago. It is now being looked at as a very potent medication for use against cancer because it blocks the growth of very small vessels that are necessary to nourish cancer. That's called anti-angiogenesis. Thalidomide is an

anti-angiogenic compound. It is being looked at for a variety of cancers.
Q. Does that include renal cell cancer as well?
A. Yes, I believe it is.
Q. This again is the discharge summary, the second page of the discharge summary. There is a highlighted portion up there. We don't need to read it to the jury because they can read it themselves. If you could read it to yourself and tell me what the significance of that is. I see there is a "secondary effect of the thalidomide" and so forth.
A. Yes. That essentially states that the family elected, in the face of this very serious condition, to continue with therapy. And that the thalidomide was started, and that the side effect associated with thalidomide, which is sleepiness, somnolence, he was being treated for that with Ritalin to try to offset that.
Q. We have a course of interleukin that was started and stopped because of side effects, then we have another drug that's being tested or tried for kidney cancer as well.
Does that support your opinion in this case that Mr. Allen was suffering from renal cell cancer?
A. Yes.
MR. CESARANO: May I approach the witness, Your Honor?
THE COURT: Yes, sir.
BY MR. CESARANO:

Q. Doctor Manyak, I believe you were asked about this article in the National Renal Cell Cancer Study?
A. Yes.
Q. I would like to direct your attention to page 197 of that article where it states, "The magnitude of the association between cigarette smoking and RCC is moderate and would be difficult to detect in a small study or in one using hospital controls where the prevalence of smoking is likely to be higher than in the general population."
Could you explain to us what that means, please?
A. I think it's self-explanatory from the standpoint of the association of renal cell carcinoma and cigarette smoking to be moderate. What he is pointing out here in his comment is that when you look at a study, you can't take a small study and extrapolate and say this is what happens over thousands of people because the statistics are not strong enough to support that.
One of the very important things that we look at whenever we look at a study to review it before it's published

is how strong is this statistical conclusion. Then you can draw from there. What he's saying is that several of these studies are small and don't support a strong association with kidney cancer in smoking.
Q. I want to ask you also about this article. You were asked about this one, Epidemiology of Renal Cell Carcinoma?

A. Yes.
Q. Over here there is a section on body weight.
A. Okay.
Q. It states, "At least five case controlled studies, four from North America and one from China, reported a significantly elevated risk of renal cell cancer in association with body weight with an OR" -- is that the odds ratio?
A. Yes.
Q. -- "with an OR of 2.7 and 2.5 in men in the highest body mass index level, and OR from 2.2 to 3.6 for either sex, with significant trends in risk. An American study found a forty percent increase in risk which was significant only in men."
Do you agree with that statement or is that what your research has shown or turned up?
A. I think, again, this points out to the fact that there is an association in several studies with obesity or overweight and renal cell carcinoma development. Again, this literature is erratic in some respects. This is a discussion of five different case control studies, which is the right kind of study you have to do to determine whether a factor is affecting, in this case, cancer. Case control studies are appropriate to have the right thing to measure it against to see if it's effective. That's, I think, fairly strong evidence to suggest that their conclusion is solid.
Q. So in talking about risk factors now, and that's what these

two studies addressed, and that's what you were asked about on cross-examination by Mr. Cohen, how does -- according to the literature and the research that you're familiar -- let me back up a minute.
Let me ask you, first of all, you looked at a number of different studies and articles on research; did you not?
A. Yes.
Q. Why do you look at a number of them? Why do you look at several?
A. Well, I think you want to get as much of a balanced approach to an issue as you can. Unless there is something that is strikingly definite about one paper or one report, it is common practice for us to get as many reports as we can to look at the issue. Not only just for this, but for everything we do in medicine.
Q. When you get as many reports as you can, those reports or those studies will cover the entire range of findings, will they not?
A. Hopefully, that's the plan.
Q. That's the reason why you look at so many, so that you can see the entire range of research, results and findings, correct?
A. Yes, because some studies may have flaws. If you rely on just one, then you may come to the wrong conclusion.
Q. You do that so that you are able to come in and present the

entire picture, correct?

A. Yes.
Q. Talking about risk factors, in the course of the research and the studying that you have done, how does cigarette smoking compare as a risk factor to the other risk factors that Mr. Allen had which include hypertension, obesity, being a male, being in the age group of fifty to seventy?
A. And diabetes.
Q. And diabetes.
A. Looking at the risk factors of diabetes, hypertension and obesity and comparing them to the cigarette smoking issue, they are at least equal to each other. In several cases obesity and hypertension and diabetes are a little higher. I think that's probably not statistically significant. It would be a very fair statement to say that they are about equal as far as their relative risk association.

Regarding males and being a male and being in the age range, there is a fairly high association with that. We know that kidney cancer occurs twice as often in men as in women. That certainly would increase his risk. He was in the right age range for the peak incidence of kidney cancer.
Q. When you say kidney cancer occurs twice as often in men as in women, does that mean that odds ratio or the relative risk, I'm sorry, is two?
A. No, you know, I am not sure I can answer that

appropriately. Not being a statistician, I am not comfortable trying to estimate that.
Q. Okay. In someone such as Bob Allen who has all of these various risk factors, including age gender and the other ones we have talked about, is there any way that you can conclude or anyone can conclude what caused his renal cell carcinoma?
A. No, I don't think you can.
Q. You were asked about some statistics from the American Cancer Society?
A. Yes.
Q. Do statistics tell us what type of cancer Bob Allen had?
A. No.
Q. You told us on cross-examination that his course of treatment was just one piece of the evidence that led you to your conclusion. What are the other pieces of evidence that you considered other than his course of treatment, other than the medication that was administered and other than the pathology? You used all of those three, correct?
A. Yes.
Q. What else did you --
A. I think the first important piece is the pathological diagnosis that was rendered by two different pathologists stating this is consistent with renal cell carcinoma.

Secondly, the clinical course that occurred with the development of a renal mass that progressed in size and that

other lesions showed up in other places is important and strongly suggests renal cell carcinoma.

The fact that the occurrence of the discovery of the metastatic deposit in his foot that was biopsied is very consistent with renal cell carcinoma. In fact, that is the most common type of cancer that occurs when you find a metastasis in the foot.

The clinical course clearly supported that. Very strong evidence is seen on the records that we looked at and went through in detail yesterday with the CT scan demonstrating

at the time of diagnosis, clearly a renal mass that was solid and would be, in my opinion, very, very highly suspicious for kidney cancer at the time of his original diagnosis. Putting all of that together is very strong evidence. That's why I say whether or not the interleukin had any relative play or not is a relatively lesser piece of information.

It's somewhat supportive. But the strong facts are the appearance of the x-rays, the pathological diagnosis and the clinical course of this patient's problem. That is, it's renal cell carcinoma. That's what it is.

Q. You were also asked some questions about renal cell carcinoma and the differences between renal cell and transitional cell carcinoma?

A. Yes.

Q. Transitional cell carcinoma, and you explained a little bit

to the jury yesterday what the cross-section of the kidney, where it arises in the collection area?

A. Yes.

Q. You also were asked about cancers of the renal pelvis and ureter. Is that renal cell carcinoma, cancers of the renal, pelvis and ureter; is that the same thing?

A. No, no, no. That transitional cell carcinoma. Transitional cells line the collecting system, which is that area where it all collects before it goes down the ureter, renal is the tube that goes to the bladder. That area is called the renal pelvis. It's where the collecting system comes together and forms a little pool and then goes down the ureter. That's all transitional cell carcinoma.

Q. If it were a transitional cell, you would expect to see a tumor in that area?

A. Yes.

Q. Whereas, in our case we saw it on what's called the cortex?

A. Yes, it was on the periphery, which is completely different. You may see a transitional cell in the internal portion of the kidney that looks like it's coming from the solid tissue. When it has arisen from that internal renal pelvis area, it wouldn't appear like that. It wouldn't appear like what we saw there, which is clearly an external peripheral lesion that is just starting to contour of the kidney.

Q. The association between smoking and cancers of the renal

pelvis and ureter, or transitional cell, is higher than the association between smoking and renal cell carcinoma, correct?

A. It's very significantly higher, yes.

Q. Let me show you an article entitled Cigarette Smoking and Cancers of the Renal Pelvis and Ureter.

MR. COHEN: Point of clarification, is that one of articles we went over?

MR. CESARANO: You did not address this article on cross.

MR. COHEN: Then I object. One, it's redirect and it's bolstering.

THE COURT: Has this article been shown to or furnished to the plaintiffs?

MR. CESARANO: This article was shown to Doctor Feingold by the plaintiffs.

THE COURT: Was shown to --

MR. CESARANO: Doctor Feingold in their direct examination.

THE COURT: I see. So the plaintiffs have reviewed.

Do you understand what the article is? We didn't get the author, but show him a copy of it. All right. The objection is overruled. You may ask him about it.

MR. CESARANO: That has been marked as Defendant's Exhibit PM481.

THE COURT: Thank you.

BY MR. CESARANO:

Q. Let's go straight to the conclusion or the abstract of this article. Could you explain what this article indicates with respect to the association between cigarette smoking and transitional cell carcinoma?

A. Yes. The title is Cigarette Smoking and Cancers of the Renal Pelvis and Ureter. It is by McLaughlin, again, who is an author on some of these other papers that we have discussed, and some people from the National Cancer Institute that I know.

The conclusion says, "The attributable risk estimates indicate that approximately seven of ten cancers of the renal pelvis and ureter among men --"

THE COURT: A little bit slower.

THE WITNESS: I apologize. I'm sorry.

THE COURT: A little bit slower. When you are reading it goes fast.

THE WITNESS: You are right. I apologize.

THE COURT: Could you back up just a little?

THE WITNESS: Sure. I will start over with the conclusion. It says, "Attributable risk estimates indicate that approximately seven of ten cancers of the renal pelvis and ureter among men and almost four of ten among women are caused by smoking."

"The results of this study, the largest to date, confirm that cigarette smoking is the major cause of cancers of

the renal pelvis and ureter, and the cessation of smoking could eliminate a large portion of these tumors."

BY MR. CESARANO:

Q. Just to make clear, Mr. Allen did not have cancer of the renal pelvis and ureter, did he?

A. He did not.

Q. You were also asked a series of questions of cancer metastasizing and spreading, I believe from the lung to the kidney. If, in fact, Mr. Allen's cancer had been a lung primary and had spread to the kidney, what would you have expected to see in the radiographs and the records and so forth that you reviewed?

MR. COHEN: Objection, Your Honor. This is repetitious. It was gone over on direct.

THE COURT: Well, a certain amount of going back over some of the direct is permitted, but I think that we have gone pretty much in depth. I will let you go a little further. If it is in the record, it is, of course, arguable to the jury. He doesn't have to repeat it. A certain amount of that is permitted. Go ahead.

MR. CESARANO: Thank you.

THE WITNESS: I think we covered, as you say, yesterday in showing the photos of what the classical appearance of lung cancer going to the kidneys is. That is, that it happens on both kidneys, and it happens on multiple

locations. That's what we would expect. Over the course of

time we see only still the one lesion in the kidney. That, to me, very strongly supports that this was primary kidney cancer and not metastatic lung cancer. We would expect other deposits to show up.
BY MR. CESARANO:
Q. Mr. Cohen asked you also about whether or not lung cancer could spread to the bone. What is the most common type of cancers to spread to the bone? Is lung cancer the most common type that will spread to the bone?
A. It is not the most common, no. It is one that does go to the bone, but it's not the most common.
Q. What in your opinion is the most common?
A. Prostate cancer is the most common. There are essentially five tumors that go to bone. Prostate, kidney, thyroid, lung and breast cancers all are known to go to the bone. Prostate being the most common. Kidney being the second or third most common ahead of lung cancer going to the bone. Occasionally, colon cancer can go to the bone too. It happens about ten percent of the time.
Q. Is kidney cancer more likely to spread to bone than lung cancer?
A. Yes, on a statistical basis, yes.
MR. CESARANO: Thank you. May I have just one moment, Your Honor?

THE COURT: Sure.
MR. CESARANO: Thank you. That's all I have.
THE COURT: Thank you, Doctor Manyak. You may step down.
THE WITNESS: Thank you, Your Honor.
THE COURT: Ladies and gentlemen, it's 10:35. We have been in session for one hour and a half. We will take a fifteen-minute recess and resume at ten minutes to eleven. You folks step into the jury room, please.
[The jury leaves the courtroom.]
[There was a short recess.]
THE COURT: Bring in the jury, please.
[The jury returns to the courtroom.]
THE COURT: Thank you. Be seated.
Your next witness, please.
MR. REILLY: Thank you, Your Honor. Our next witness is Doctor Eric Kaplan.
COURTROOM DEPUTY: State your name, please, spelling your last name for the record.
THE WITNESS: Eric Michael Kaplan, K-a-p-l-a-n.
ERIC MICHAEL KAPLAN, DEFENDANT'S WITNESS, SWORN.
DIRECT EXAMINATION
BY MR. REILLY:
Q. Doctor, would you please tell the jury your name?
A. Eric Kaplan, M.D.

Q. Please tell the jury your profession.
A. I am a medical doctor and a psychiatrist.
Q. Can you tell me where you are licensed to practice medicine?
A. I'm licensed in the State of Florida.
Q. Tell me where you live.
A.
[DELETED].
Q. How long have you been practicing psychiatry?
A. I completed my residency in 1990, so I have been in private

practice for approximately thirteen years.
Q. Can you tell the jury what the practice of psychiatry is about. What is psychiatry?
A. Sure. Psychiatrists are the medical physicians that specialize in diagnosis and treatment of people who suffer from various mental illnesses. In addition, we are responsible for diagnosing and treating people who have problems with substance abuse disorders. We are the specialists who focus on behaviors, and if people want to make some changes in behaviors, we assist them.
Q. Can you tell the jury where you went to medical school?
A. I went to medical school right here in Miami. That was 1982 to 1986.
Q. Doctor, during the time that you were in medical school, did you receive any honors?

A. I did. I received an award. I think it's the Herman Selinsky award, something like that. Each year at University of Miami they give an award to the student who did best in psychiatry rotation, so my fourth year of med school I won that award.
Q. While you were in medical school, did you do work in the area of substance abuse?
A. I did.
Q. Tell the jury about that.
A. As part of every medical student's training, the first two years is pretty much like going to high school in terms of you sit in a class and they teach you a lot about medicine, medications, illnesses, things like that. As part of that education, you learn about psychiatry and mental illness and you learn about substance abuse disorders and you learn about tobacco-related illnesses and treatments and nicotine and pharmacology of nicotine.
In the third year you get to meet with patients and you learn how to do physical diagnosis and treat illnesses. During the third year you go through all your different rotations.
In medicine, I had the experience of working with patients who had various respiratory and other disorders. You do rotation in psychiatry. In the psychiatry rotation, I had experienced not just book learning, but clinical experience

working with patients who had different mental illnesses and substance abuse disorders and some issues regarding nicotine and tobacco use and helping people stop smoking, if they were interested.
Finally, in the fourth year you get to pick more of what they call an elective. I was always interested in psychiatry, so I took more psychiatric courses and rotations, and as part of that a lot of the focus was substance abuse disorders, and that included people that were smokers who wanted to stop. That's the different experiences in medical school.
Q. Doctor, did you go to more than one medical school? Did you also attend other medical schools aside from University of Miami?
A. During the fourth year you get to do what they call externships. I was always a student at the University of Miami. You get to try out other med schools to see, you know, perhaps you would like to do your residency there or they may offer some classes that they didn't have at Jackson Memorial.

So I went to University of California, Davis, which is in Sacramento, California. I did I think it was a two to three-month rotation on an inpatient psychiatry unit.
They had people with a variety of psychiatric illnesses. Also, they had a substance abuse unit there. Again, I got additional training in how to treat people, how to

diagnose, how to help people who had different substance abuse disorders, how to learn to live drug-free, those kind of things.
Q. Doctor, I think it's a forgone conclusion you did a residency in psychiatry?
A. Yes, I did.
Q. Tell us where you did that.
A. I decided to stay in Florida and decided to go to University of South Florida in Tampa for their psychiatry department. Let's see, that was 1986 to 1990.
Q. Did you receive any awards during your residency?
A. I did. I was chief resident my last year. I received an award for the resident who they felt did the best during the residency. I think that was the Hibbs-Bourkard award, something like that. Then I did a paper on psychiatric aspects of AIDS. So I received an award for that also.
Q. Doctor, can you tell the jury if you worked on substance abuse issues for care and treatment of patients during your residency?
A. Sure. A lot more than med school. That was a focus. Psychiatry residencies are four years. The first year really the focus is internal medicine. You actually are working with the internists training, and you do about three or four months as a neurologist.
So the first-year training was a lot of the medical

aspects of substance abuse disorders, what can happen if people abuse substances and medical complications and withdrawal issues and how to treat them medically, and then the last three years were focused on actually being a psychiatrist, learning how to really delve into understanding these abuse disorders. And we had training treating people outpatient and treating people on an inpatient unit. It's a lot more extensive training.
Q. During your residency, were you involved in substance abuse clinics?
A. Yes. In the hospital itself, worked in several hospitals on a rotation. Basically, all you do for six months or a year is treat patients on these inpatient units. There were a wide variety of types of patients, people who had alcoholism and cocaine abuse or dependence, and heroin and other narcotic abuse problems. Some of them were smokers and some of them were interested in stopping, so we had experience in treating people who wanted to stop smoking.
In addition, at the V.A. Hospital, which is the James A. Haley Hospital, that's in Tampa, they had a smoking cessation clinic. I think it was approximately six months, but I had experience working in that clinic trying to help people who were interested in stopping smoking.
Q. Doctor, after you completed your residency, what did you do after your residency?

A. I met my wife during residency and we decided to make a

life in Tampa. Stayed in Tampa, Florida, and started an outpatient office. At the same time, I had the good fortune, they were opening up a new psychiatric hospital a little north of Tampa in Pasco County, which is the county north of Hillsboro County, which is Tampa, and they asked me to run their adult inpatient unit.

So I had kind of a mixed practice. I treated patients seven days a week in the hospital who had different mental illnesses and substance abuse disorders. I ran their adult inpatient program. Then usually I would see them until about eleven a.m., and then I would go to my outpatient office and I treat people in an outpatient clinic, my office, about five days a week.

Q. What kind of substance abuse patients were you dealing with?

A. We had a separate alcohol and drug treatment program. Mostly inpatient, but some outpatient. A wide variety. Similar as in med school and residency. People with alcohol abuse problems. Cocaine was quite a problem. Narcotics, like heroin, was a big problem. Some people who have serious abuse in marijuana, although that was not common. Again, as it relates to smoking, some of those people smoked, some didn't. Other people who smoked, if they wanted some assistance in stopping, we certainly tried to help them.

Q. Did your responsibilities at Charter change over time?

A. They did. About two years after I started there the medical director left. The medical director is the chief doctor in charge of the hospital as it relates to medical issues. They asked me to kind of step up and run the hospital, so I became medical director at Charter Pasco, and I stayed medical director there for --

THE COURT: I am slowing you down a minute.

THE WITNESS: I'm sorry.

THE COURT: Approximately when was that?

THE WITNESS: I became medical director approximately 1992.

THE COURT: Okay. Go ahead.

BY MR. REILLY:

Q. As slowly as I talk, Doctor, I thought maybe we would even each other out.

A. I'm sorry. I have a tendency to talk a little quickly. I stayed medical director until approximately 1997.

Q. Can you give the jury a sense of how many substance abuse patients would have been patients at Charter during the time you were involved in that program?

A. Sure. I am not going to be exact with the number because there's no way I can recall. Patients running through the program from the whole time I was there, probably in the thousands. Patients who I personally treated them as their own

physician, six hundred, seven hundred. Something like that.

Q. Those are just substance abuse patients, patients that have alcohol problems or heroin problems or cocaine problems, things of that nature?

A. Correct. In addition, I treated patients on the adult unit and the geriatric unit and sometimes the child and adolescent unit. Those people usually suffer from depression who are manic depressive disorder or panic disorder or Alzheimer's disorder for people on the geriatric unit. So it varied.

Q. Did you design a smoking cessation program while you were

there?
A. I was part of a group. Actually, a few years after I started there, I also ran the alcohol and drug program. I was director of that as well as being director of the hospital. Part of what we did there is for people that were smokers who were interested in stopping, we developed additional therapies for them, a smoking cessation track, so to speak.

I was part of a committee that put together information, types of treatments, medical-psychological behavioral therapies to help them stop smoking. I also was involved in a similar track at another hospital that I consulted at.

Q. I'm going to ask you if you worked at more than just Charter Hospital, but do you have any sense of how many patients would have gone through your smoking cessation program

at Charter?
A. Again, probably in the thousands. In terms of me actually being their doctor and working with them, that would be in the hundreds.

Q. Doctor, did you have responsibilities at other hospitals aside from Charter?
A. I did.
Q. Tell the jury about that.

Sure. It's pretty common for psychiatrists to do consultation liaison work. That's a fancy name. It just means that another medical doctor who's not a psychiatrist wants some guidance in treating psychiatric illness or substance abuse disorders, they ask us for a consultation. I would do consults at several hospitals: University Community Hospital, the teaching hospital which is Tampa General Hospital, and another teaching hospital which was the University Psychiatric Center. Then there was a hospital called Care Unit of South Florida. That is a separate and distinct alcohol and substance abuse hospital.

So when they had a person who had a psychiatric issue or they wanted some guidance in helping treat that person, I was their primary psychiatrist who they consulted with.

Q. Doctor, did you assist people in quitting smoking at those other hospitals?
A. I did. Not that much at Tampa General and University

Community. But at Care Unit of South Florida, as I mentioned, part of what they had was a separate track that they added to patients who were alcoholics or other substance abuse disorders who wanted to stop smoking. I was part of a committee that helped design some of these programs that provided psychological therapies, behavioral therapies, when appropriate, some biological medication therapies to help people stop smoking who were smokers.

Q. Doctor, do you have any medical teaching responsibilities?
A. I do. When I finished my residency in 1990, I joined a clinical faculty at the University of South Florida psychiatry department. Basically, what that means is I am a volunteer. I volunteer teaching medical studies, and I volunteer teaching residents how to perform psychiatric evals, how to treat various disorders.
Q. How long have you been doing that?
A. Since 1990.
Q. Doctor, can you tell this jury if you are board certified?
A. I am. The main board for psychiatrists is the American

Board of Psychiatry, Neurology. I am board certified by that. A few other boards that I'm a member of, The American Board of Disability Analysts, and the American Board of Forensic Medicine.
Q. Doctor, when did you become board certified?
A. As soon as they let me. The way it works is you finish

your residency. Approximately a year after going to practice, they let you sit for the written boards. You take a test. About fifty percent of psychiatrists pass it. If you pass it, then they let you sit for the oral boards where you actually will meet in front of a group of doctors and patients and they ask you a whole bunch of questions. If you pass that, then you are board certified. I passed both whenever I was allowed to take those tests.
Q. Tell the jury, what is psychopharmacology?
A. Psychopharmacology is the study of how medications or other substances affects the brain, so it affects the brain in terms of what chemicals these medications can influence and different parts of the brain like receptors that these chemicals can influence.
Q. Doctor, have you published in peer-review journals on the subject of psychopharmacology?
A. I have. Psychopharmacology is one of my real interests. I have performed different medical studies, and I have published on various issues regarding psychopharmacology.
Q. Have you lectured on the topic of psychopharmacology?
A. I have and I do. I enjoy lecturing. I lecture mostly to physicians and I teach them in several areas. I like to teach clinicians how to recognize and treat mental illnesses, like depression, both psychotherapy and medications, although my focus is medications. I do a lot of lecturing on

anti-depressant medications and other medications in terms of the psychopharmacologies or how these medications actually affect brain chemistry and then how they affect people when they take these medications.
I have done some research on withdrawal syndromes, medications that absolutely are not addictive, like anti-depressants, I've done some research on withdrawal. Even though they are not addictive, people can go through withdrawal symptoms. So I've done some research on that also.
Q. You are a very fast speaker, Doctor.
A. I am sorry about that.
Q. I will slow this down just a little bit.
Doctor, can you tell the jury whether or not, in lecturing, you have lectured on psychopharmacology both here and abroad?
A. I have. I have lectured all over the United States and I have lectured on psychopharmacology in some other countries, France and Scotland.
Q. Can you tell the jury if you have lectured on psychopharmacology as it relates to nicotine?
A. I have, although that's not a primary focus of my presentations. I have lectured on the topic of biologically, how to treat nicotine dependents. Some anti-depressants have been approved for the treatment of nicotine dependents. You may have heard of a medication called Zyban. Zyban is an

anti-depressant. Wellbutrin is another name for that. As part

of my presentations, I have lectured on the many uses of anti-depressants.

Anti-depressants are used not just to treat depression. We treat anxiety disorders and obsessive compulsive disorders and some substance abuse disorders. I have given lectures on how anti-depressants can be used in the treatment of nicotine dependence.

Q. Can you tell the jury whether or not you are involved in research for drug therapy for nicotine dependence?

A. I haven't been, although I just completed a protocol. There is a new medication just released called Strattera. Many of you may not have heard it because it was just released. It is for children and adolescents and adults who have attention deficit disorder, ADD or ADHD.

The way it works, which chemicals it works on, it may provide some benefit for people who want to stop smoking. I started a protocol in terms of doing a research study. I am just in the initial stages. A protocol just means the steps you will go through to start a study. What kind of patients and how do I find out they have a diagnosis and how do I know if the med's working or not?

I have not gotten any patients yet for this study, but I am going to start it. It is an interest of mine.

Q. Doctor, can you tell us if you are a member of any

professional psychiatric organizations?

A. I am. I have been a member of the American Psychiatric Association since I have been a resident in psychiatry.

I am a member of the Florida Psychiatric Society, which is our state organization.

I am a member of the Tampa Psychiatric Society.

In addition, I'm a member of the American Board of Disability Analysts, which is a society, and the American Board of Forensic Examiners.

Q. Doctor, you have a private practice today, correct?

A. I do.

Q. Can you tell the jury about your private practice?

A. Sure. I have a practice in the northern suburb of Tampa. Like many psychiatrists, I see people who suffer from a variety of mental illnesses and substance abuse disorders. I do a lot of work with depressed people. I enjoy treating that.

THE COURT: With which people?

THE WITNESS: People who have depression, depressed.

THE COURT: I thought he said with the press people. It caught my attention. You are talking about lawyers, depressed people.

THE WITNESS: Correct.

THE COURT: I am sorry for the interruption.

THE WITNESS: No problem. With depressed people. People that suffer from clinical depression. A lot of anxiety

disorders. People who have panic attacks and obsessive compulsive disorder. I also see outpatients who have substance abuse disorders. Alcoholics, people who abuse cocaine, people that abuse heroin and other narcotics, which is actually more common. People who abuse prescription medications. Things like that. Some of my patients are smokers, and my patients that are smokers who want to stop, I certainly try to assist them in stopping their smoking behavior.

BY MR. REILLY:

Q. Doctor, can you give the jury a sense of how many patients

you have treated in your private practice, not the hospital-based practices you've already talked to us about, but your private practice, there have been people who -- in addition to the other treatments that they are seeking you for, they have also sought assistance in dealing with smoking?
A. Sure. Over the years I've treated thousands of patients in my outpatient practice. I currently treat about eight hundred or a thousand outpatients. Of those patients, over the years, I have probably treated two to three hundred patients who were smokers who wanted to stop smoking. That would be just in terms of outpatient experience.
Q. All right. Doctor, can you tell us, of the patients that you treat, do you treat patients who have other kinds of compulsive behavior disorders unrelated to drugs or things of that nature? Just people who have compulsive behavior

disorders?
A. Sure, that's actually pretty common for psychiatrists. There are groups of behaviors that cause problems in people's life that involve compulsive behaviors. People that are gamblers, people that are compulsive overeaters, people that have compulsive buying or sexual compulsive disorders. I treat people who have those kind of problems. Sometimes the term "addiction" is used to describe those. They are essentially compulsive behaviors that cause problems in their life.
Q. Doctor, do you also have, as part of your practice, a forensic psychiatry practice?
A. I do. What that means is that I am involved in medical-legal work. Probably about twenty percent of my practice is focused towards that. As I sit here today, I am in a tobacco-related case. I do some of that kind of work. I do work as it relates to psychiatric illness. If someone suffers from a disorder and they say they "can't work, I'm disabled because of that," I do that kind of work.
I do some psychopharmacology legal work. If someone is on a medication or has an illness and a crime is committed as a consequence of that, sometimes people ask me to consult in cases like that.
Q. Doctor, have you been called upon by the State of Florida to testify in legal matters?
A. I have.

Q. Can you explain that kind of situation to the Court and jury?
A. Sure. I have been involved in two cases. They were called the Prozac defense trials, where someone committed a crime and they were on an anti-depressant, in this case Prozac. I was asked by the State of Florida to evaluate the psychopharmacology of Prozac and other anti-depressants and if any of their criminal behaviors were a consequence of that. I have been involved in two of those cases during the last six or seven years.
Q. Doctor, when you do that kind of work, are you compensated for your time?
A. I am compensated for my time for any type of forensic work I do.
Q. Can you tell the Court what your hourly rate is for that?
A. Sure. I charge $300 per hour for any forensic-related professional services.
Q. Doctor, have you ever testified in a case involving a cigarette manufacturer before?

A. I have.
Q. On how many occasions?
A. This is my third time on the stand. So two previous occasions.
Q. In those cases in which you have testified in legal matters has your expertise been accepted by the Court in those cases?

A. It has.
MR. REILLY: Your Honor, at this time I would tender Doctor Kaplan as an expert in psychiatry and substance abuse and the treatment thereof.
THE COURT: Okay. Not working?
MR. YAFFA: Not working, and no objection.
THE COURT: Let's see if we can get it working somehow or the other here.
MR. YAFFA: Regardless, Your Honor. I walked up to this podium. We don't have an objection as to these two areas that he's being offered.
THE COURT: Thank you. Still, we need to get it fixed. It's a brand-new system. I think they put the controls in last week or the week before. The microphones and things may have been a month ago.
Then, Doctor Kaplan is recognized as an expert in his field of psychiatry and therefore entitled to express opinions to you, as you understand. Mr. Reilly?
MR. REILLY: Thank you, Your Honor.
BY MR. REILLY:
Q. Doctor, when you are dealing with a patient who has a substance abuse problem, is part of what you do to determine their ability to quit whatever the substance is?
A. What is part of what I do?
Q. Yes.

A. I certainly want to understand why they are using substances. I first want to understand if they want to stop. I mean, that's incredibly important. If someone doesn't want to stop, they are not going to be successful, generally. If someone wants to, that certainly helps.
Then we want to evaluate how motivated a person is to follow through with the goal of stopping and try to understand their commitment. Are they willing to follow through with the various types of therapies that are often helpful to help people stop?
Q. Doctor, is that true with regard to what the substance in question is?
A. I think that's true for any type of substance. I think that's true actually for any kind of behavior. If you want to change your behavior, being motivated, being committed, I think, are very important qualities or characteristics.
Q. You sort of anticipated the question I was planning on asking you, but I will get to that in a little bit.
How is it that psychiatrists are qualified to determine somebody's motivation, their ability to quit, in effect?
A. Psychiatry is the field of understanding how people tick, so to speak; human behavior, what goes behind, why people do what they do, and more importantly, if people need to make changes in their behavior, if they want to, how to assist

people in being successful in making behavioral changes, and

hopefully those behavioral changes are changes that are healthier for them, so to speak.
Q. Doctor, when you have patients that come to you who are smokers, do you recommend that they quit?
A. Oh, sure. All of my patients who are smokers I recommend to them that it would be healthy for them not to smoke. Some agree and want to try to stop, and others tell me no, they're going to continue to smoke.
Q. Can they rationally make those decisions?
A. Sure. I don't think that's a good decision, I don't think that's a healthy decision. But people rationally decide to do a lot of things that I may not think is in their best interest, but for whatever reason, they decide to continue those behaviors.
Q. Can you give us an example of other things that you recommend to people that they rationally can decide not to stop, but that you think are not in the best interest of them from a medical standpoint?
A. Sure. As a physician, I am a psychiatrist, so my specialty is to focus on mental illnesses and substance abuse disorders, but I want my patients to be healthy. If I have a patient who is overweight who has high cholesterol triglycerides, I am going to try to get them to have a healthier diet, to eat better things, to exercise. I certainly recommend that. In

fact, I think exercise is wonderful for psychiatric illness also. Sometimes they listen to me. A lot of times they don't. It's their choice to decide if they want to change their behavior.
I have patients who are compulsive gamblers. Certainly not a healthy behavior. Causes problems in their life financially, with their spouses, with their children. Try to get them to stop. A lot of times they choose not to.
There are a whole bunch of different kind of behaviors that we human beings do. It may not be in our best interest, but that's part of being human. We can choose to do things we want to if we, in our own minds and hearts, we enjoy it. That is not uncommon in clinical practice.
Q. Doctor, I have prepared a board. Do you mind stepping down?
[Witness exits the witness stand.]
BY MR. REILLY:
Q. Doctor, look at the board and tell the jury whether or not those are the pleasures or benefits that people who smoke appreciate or enjoy.
A. Yes, this is a chart that looks at the various benefits, pleasures that people that are smokers have described to myself and other people regarding smoking. They find the behavior pleasurable. Some people feel relaxed when they smoke cigarettes. A lot of people would describe the feeling of

being less stressed, so they may smoke when they are more stressed. Smoking can improve concentration, attention span. Focus, that's very common. Energy, people can feel more energized when they smoke, but also more relaxed. You kind of feel both.
Socialization is a very important factor. People take smoking breaks. They talk with their friends when they are smoking, what was on T.V. last night, what kind of football game. It's a social kind of behavior.
Taste, some people actually enjoy the taste and the

feel inside their mouth and the smell of cigarette smoke.
There are a variety of reasons in different people. Some are more important than others.
Q. Doctor, I think a minute ago you were talking about the principal factor in whether or not someone says they want to quit smoking. What is the principal factor in determining whether they will succeeded in quitting smoking?
A. The principal factor is do they want to stop, number one. Then, if they want to stop, are they motivated to stop, are they committed to follow through with a program? But the first thing is are they willing to stop smoking and give up what they perceive as some benefits of smoking for them.
Q. Can you tell the jury, if a patient indicates to you that they are motivated and they are prepared to give up these benefits and they have decided they want to do that, what are

the treatments and assistance that you have available to help them quit smoking?
A. There are a lot of ways to help people change their smoking behavior. As one example, if they are motivated, I try to provide -- and this is common, this is just not myself. A lot of clinicians who try to help people stop smoking do this -- there are behavioral methods and there are biological medical methods. The Department of Health and Human Services recommends that we use a combination that has your highest success rate.
Number one, I want to support them, and I want to get family members and other people to really encourage and support them. Hey, you can do it. Stick with it day by day.
In terms of behavioral therapies, there are a whole bunch. It seems like if you individualize the treatment for the patient, you seem to get the best response. Some people like to do relaxation exercises. You can teach them how to relax their mind and their body. That's important. You can teach them some self-hypnosis. Again, physical exercise, I am a big fan of that. It is a great way of blowing off stress and feeling better physically. Sometimes people go for hypnosis. So those are various psychological therapies.
Sometimes support groups are really helpful. Other smokers, telling people, "You can do it." That's very common in any substance abuse or dependence programs. Biologic

therapies, there are many different biologic therapies we can offer. And pretty much nicotine replacement therapies, and you can replace nicotine by various methods.
Since the mid '80s, nicotine has been available in gum. A lot of you are familiar with that. In the '90s, we had nicotine available in patches people can wear. Just recently, like a month ago, there's lozenges. There is nasal and oral inhalers. You can actually inhale nicotine that way. As I discussed previously, that anti-depressant Zyban can also be helpful in reducing craving and helping people to stop smoking.
To be honest, a lot of these biologic techniques have not been shown to be all that effective. But again, it's another piece of the puzzle and a lot of times we'll combine these therapies to help people who want it.
Q. Doctor, is there any reason to offer any of that if their patient indicates to you they have no desire in quitting smoking?
A. Not really. If someone is unmotivated, and again, I think this is true for any type of behavior that we've done a lot of

times in our life, that we enjoy. If someone really doesn't want to stop, you can offer a bunch of these therapies and most likely they are not going to be successful. In fact, most people who have been successful in stopping smoking, the overwhelming majority, they don't see a psychiatrist, they don't see an internist. They just stop cold turkey. They

don't take any medications for it.

MR. YAFFA: Mr. Reilly, if he is not going to be using the chart, can he sit there?

MR. REILLY: Actually, he is going to be using some other charts. I guess it's a little hard to get in and out of that thing, the witness stand, so I'm happy to have him sit back down, but I will have him back up in just a little bit, Your Honor.

THE COURT: Whatever he is comfortable. That microphone, the battery, is going dead on it. It goes in and out occasionally. If he is through with the chart --

MR. REILLY: He is through with that one, Your Honor, I think. We may refer to it again, I don't know.

THE COURT: Go ahead. Finish whatever you wish.

BY MR. REILLY:

Q. Doctor, tell the jury how important nicotine is in people's smoking behavior.

A. Nicotine is one of the reasons why people smoke cigarettes. It is just one of them. To some people it's more important. In other people it's not that important. Nicotine has been available in these replacement therapies for quite a long time. People don't abuse or use nicotine replacement for pleasurable kind of feeling. A lot of these replacement therapies have not really been proven to be that helpful in the long-term of smoking.

THE COURT: Mr. Reilly, I think he should take the stand.

Take the stand, please.

MR. REILLY: Okay.

[Witness resumes the witness stand.]

BY MR. REILLY:

Q. I am sorry. Had you finished your answer?

A. No. I just have a few more things to say.

Nicotine is one of the reasons why people smoke cigarettes. As you can see in that chart, a lot of those pleasurable feelings that people get from smoking cigarettes are really unrelated, social aspects and smell and some of the other pleasurable kind of feelings related to it.

You know, in summary, yes, nicotine is part of the reason why people smoke. It's not the only reason why people smoke.

Q. Doctor, you have already indicated that most folks quit without going to a psychiatrist, but of the folks who have come to you who have indicated to you that they, in fact, did want to quit smoking, for those patients who have demonstrated themselves to you to be motivated, what is the success rate for those folks in your experience in quitting smoking?

A. In my clinical experience, if someone comes to me and they're highly motivated, that's seventy-five percent of people are successful in stopping. If someone is not that motivated,

probably the opposite, about seventy-five percent of people are

not successful in stopping.
Q. Doctor, do you know how many people in the United States have quit smoking?
A. Yes, approximately fifty million Americans, former smokers, have successfully stopped smoking cigarettes.
Q. For good?
A. For good.
Q. Among those there have been people who smoked for a very long time and a lot of cigarettes, right?
A. There would be people that have smoked for forty, fifty-plus years and have stopped, and people that just for a year or so have stopped, sure.
Q. Can you tell the jury how many people quit smoking every year on an annual basis here in the United States?
A. In the United States approximately one and a half million Americans will successfully quit smoking each year.
Q. Do you have a sense of how many or what percentage of those folks quit without any assistance whatsoever?
A. Oh, the vast majority. Ninety plus percent of people who stop smoking, actually they stop by themselves without going to any groups or hypnosis or asking any clinicians for assistance.
Q. Can it be difficult for people to quit smoking?
A. Sure, sure. Stopping smoking can be very difficult for some people. Not so difficult for others. Similar to other

behaviors. I mean if there is a behavior that you are used to that you do numerous times a day, weeks, months, years, and you like it, boy, it's hard, it can be hard to change any type of behavior. Cigarette smoking can be a good example of that.
Q. Doctor, are there withdrawal symptoms that go along with quitting smoking?
There can be. If someone is a smoker and they stop smoking, a percentage of people can develop some withdrawal symptoms. The studies vary actually. Approximately fifty percent of people who are smokers don't get withdrawal symptoms. When people do get them, they tend to be pretty mild, transient, which means they don't last very long. But you can have some withdrawal symptoms, sure.
Q. You told this jury that you have been involved in the substance abuse treatment of patients who have dealt with heroin addiction, cocaine addiction, amphetamine addiction, alcohol addiction. Do those come with withdrawal symptoms too?
A. Those can come with very serious withdrawal symptoms, sure.
Q. Can you give the jury a sense of the comparison of the withdrawal symptoms from cigarette smoking versus the withdrawal symptoms from say alcohol or heroin or cocaine, things of that nature?
A. Sure. They are really very different. Let's start with alcohol, for an example. If someone is an alcoholic, they have been drinking a large amount for a period of time. We

generally have to hospitalize them because the withdrawal from alcohol can actually be lethal. There are several things that can happen.
First of all, people can have seizures, grand mal seizures, convulsions, and some people can die from that. People can have DTs, that's called delirium tremors. Very dangerous. Fifteen percent of people who have DTs actually die as a consequence. What that means is that blood pressure goes really high, heart rate goes high, they sweat, and they hallucinate. They feel spiders, ants crawling on their body or

see spiders and ants crawling all over the wall. It's really something. Very dangerous. We hospitalize people who are alcoholics for that reason. We treat them with medications to prevent that from happening.
Q. What kind of treatments?
A. There are different kinds. What they all have in common is it makes it harder for a patient to have a seizure. They will raise the seizure threshold. We use anti-convulsants. We use tranquilizers. We use barbiturates. It makes it more pleasant. They still suffer, but it makes it more pleasant and they don't go through these DTs.
Q. I stopped you. You were just talking about alcohol. How about heroin?
A. Heroin is not as dangerous physically, but it's nastier in terms of how it feels to the patient. If someone is abusing

heroin and they stop for twenty-four hours or greater, they go through a very, very difficult withdrawal. Nobody dies from heroin withdrawal, but it is incredibly uncomfortable. People will describe almost like the feeling of someone stabbing them in the stomach, a terrible abdominal cramping. People throw up and have diarrhea and they sweat, and an unbelievable craving for a narcotic, for heroin. This is part of the reason why we see so much crime, people prostituting themselves, things like that, to get heroin because the craving is so intense.
Cocaine is another example, especially crack cocaine. People that abuse cocaine, they describe an incredible high feeling. The highest high you can ever have in your life. Well, there's an old saying in psychiatry: If you have a high, you are going to pay for it with a down. So what happens for crack cocaine abusers is after they are high, they plummet into a terrible depression. Depression associated often with wanting to kill yourself, suicidal thoughts. They go into terrible depressive symptoms. Hard to get out of bed. Hard to think. Want to kill yourself. Those are the kind of symptoms we can see with crack cocaine abusers.
Q. Can you compare that with the withdrawals symptoms that some people have when they quit smoking?
A. Sure. First of all, I've never in my career hospitalized someone who is a smoker because of nicotine withdrawal. You don't do that. People who go through nicotine withdrawal

rarely miss work or loose out on going out with your wife or your husband or seeing your kid's softball game, or things like that. It can be uncomfortable. Generally, it tends to be more on the mild side. The symptoms are different. It's more of a mood symptom. People describe being a little irritable, a little antsy, a little anxious.
Sometimes people have some difficulty sleeping. Not the kind of difficulty where you are up all night long. It can take you a few more hours to get to sleep. Sometimes people get more hungry, sometimes people are a little less focused, and sometimes people's heart rate goes down a few beats.
So those are possible withdrawal symptoms, although again a lot of people don't have any, or if they have them, they just have a few.
Q. Doctor, in your practice as a psychiatrist, do you use the term "addiction?"
A. It depends. I like to use language that my patients understand. In our society the term addiction is generally understood by most non-psychiatrists.

When I am talking about this issue to a patient, I use the word "addiction." But when I am talking to another psychiatrist or I am dictating in a chart or things like that, psychiatrists actually use the word "dependence" instead of addiction.
Q. Is that true regardless of whether you are talking about

heroin or cocaine or alcohol or nicotine or any other substance?
A. Correct. Psychiatrists will use the term "dependence" to describe any of these drugs that fulfill criteria in certain people that are abusing them.
Q. Is nicotine in cigarettes addictive?
A. It depends on the definition. With certain definitions, yes, it is. With other definitions, no, it's not. It depends on how you are defining that term, "addiction."
Q. This jury has heard about the Surgeon General and definitions of addiction. Could you briefly explain to this jury whether or not the Surgeon General has addressed in the past the issue of whether or not cigarettes and nicotine in cigarettes is addicting?
A. The Surgeon General has addressed it several times. The first time was in 1964. At that time the Surgeon General's report looked at different criteria that you would say, yes, this drug will fulfill; yes, it's addictive; or no, it does not fulfill it; no, it is not addictive.
In 1964 the Surgeon General did not consider nicotine in cigarettes to be addictive. That changed over the years when other Surgeon General's reports came out.
Q. Could you explain what the change was and when it occurred?
A. Sure. Well, the first report they found that nicotine did not fulfill certain criteria. These criteria, number one,

intoxication. Intoxication means a drug makes you high. A drug impairs your judgment, a drug impairs your ability to make decisions. They found nicotine did not do that. They found drugs like heroin and cocaine did do that.
They did not find that there was an overwhelming need for people to have nicotine at any cost. They found that that was true for other drugs.
They found that there was no significant psychological and physiological, biological dependence on nicotine. They found that was true for other drugs.
Finally, the fourth criteria was they didn't believe that nicotine caused significant impairment to a person in society, a detriment to a person in society. For example, one was robbing others to get money for cigarettes. People were not driving intoxicated, a car, while smoking cigarettes.
So for those four reasons, they called nicotine and cigarette smoking more of a habit, habituation, and cocaine and heroin and things like that more of an addiction.
Q. Did that change in 1988?
A. It did. The definition of addiction changed drastically. It became more inclusive so that things that would not be considered addictive in the past now were considered addictive. The new '88 definition is a psychoactive substance, so it has to affect brain chemistry, that's used compulsory, used again and again. It's self-reinforcing. In other words, when you

use that, you like it and you do it again.

Using that definition, sure, cigarettes, nicotine would certainly fulfill the criteria in some people.
Q. Doctor, if we were still applying the criteria that the Surgeon General used in 1964, would nicotine be addictive today?
A. If we used the same criteria in '64, no, nicotine would not fulfill that criteria.
Q. Do psychiatrists use the term "addiction," "addicting?" Do they adopt the Surgeon General's definition of addiction?
A. No, they don't. As a society, as a group of clinicians, we have used the term "dependence" instead of addiction for several reasons. Number one, the term "addiction," I mean, there area so many definitions. If there was a hundred people and I asked everybody the definition, we would get different definitions. There is not a lot of agreement when people use that term.
The other reason was, a lot of negative connotations have been associated with addiction. Is someone weak-willed?
COURT REPORTER: I'm sorry. Would you go a little bit slower?
THE WITNESS: I'm sorry. That's my habit of talking too fast.
There has been a lot of negative connotations, negative feelings associated with the term addiction. For

those reasons, as a specialty, we have chosen to use the term "dependence" instead.
BY MR. REILLY:
Q. Doctor, is there a manual that has been published by the American Psychiatric Association called the Diagnostic and Statistical Manual of Mental Disorders that psychiatrists use in defining things like dependence?
A. Yes, in fact, you are holding it.
Q. It's pretty clear there is one?
A. It's called DSM. We're in our fourth edition. It's the diagnostic and statistic manual. That has the different criteria that have to be fulfilled, if I am going to call someone major depressant or schizophrenia or nicotine dependence. In fact, I help teach the medical students at USF how to use that kind of manual. It's been around for a while.
Q. This manual covers a heck of a lot more than just substance abuse, right, or substance dependence?
A. Correct. All mental illnesses are in there and all substance either abuse, intoxication or dependence disorders.
Q. My wife would tell you I'm in here somewhere.
Do you use this book in your practice?
A. Yes, I use it frequently.
Q. Can you tell the jury what the definition of nicotine dependence is in this manual?
A. Sure. For a person to fulfill criteria for nicotine

dependence, you have to use the substance for twelve months or greater. The use of it has to cause some kind of impairment or distress. Then there are seven criteria. To call someone nicotine dependent or to fulfill the criteria for nicotine dependence you have to have three out of seven criteria.
One would be when you stop or decrease smoking, do you get any withdrawal symptoms.
Other one would be called tolerance. In other words, do you need to smoke more cigarettes to get the same feeling from it over time, or if you smoke the same amount, do you not

get the same feeling over time.
Number three, does a person smoke more than they intended to or a larger amount than they intended to.
Number four, did the person have repeated thoughts of quitting or having trouble quitting.
Then we have the use of it is impairing one's life in terms of social life and educational life and occupational life.
Finally, is the person still smoking even though they have some kind of psychological or physical problem as a consequence of smoking. You only need three out of those seven to fulfill that criteria.
Q. Doctor, are there other criteria in that manual for substance dependence for other kinds of substances?
A. There are. The criteria for dependence are similar, but

then there's illnesses called substance abuse and there's intoxication. Different substances have different illnesses associated with them.
Q. Okay. I think I have another chart that compares the substance dependence criteria for a number of substances. Could you step down for just a minute.
[Witness exits the witness stand.]
BY MR. REILLY:
Q. Could you explain to the jury what that chart represents?
A. This is from again this manual, DSM4, and these are various substances on the left here. Different types of disorders that you can find. This is dependence. We just talked about that. Abuse, intoxication and withdrawal. This compares different substances, including caffeine found in coffee. It compares whether they will have different diagnosis.
Q. Doctor, is there something common to all of them except nicotine?
A. There is. The difference is, as you see from nicotine, you can have a dependence diagnosis and you can have withdrawal. You don't see abuse. The big difference I think clinically is you don't see intoxication. In other words, all of these drugs can intoxicate a person. It can make you high. It can impair your judgment. It can impair your ability to think, make decisions.
Nicotine does not do that. In fact, quite the

opposite. There has been some research for Alzheimer's patients using nicotine to help improve focus and concentration. That's the big difference between these different drugs.
Q. I think that chart indicates that there are withdrawal symptoms associated with those substances, right?
A. With some of the substances, yes.
Q. Does that mean that the withdrawal symptoms are the same for other substances?
A. No, they are different. As we discussed previously, the symptoms, the severity, the possible medical complications of different withdrawal syndromes can vary tremendously. Again, for nicotine it tends to be mild, tends to be kind of short-term.
Q. Doctor, I am going to let you resume your seat.
[Witness resumes the witness stand.]
BY MR. REILLY:
Q. Doctor, can you have withdrawal symptoms from behavioral changes, from non-substance situations?

A. You can. Any type of behavior that we like to do and that we do with some frequency, if you ask a person to stop it and they get some pleasure out of behavior, it is not uncommon for people to develop withdrawal-like symptoms.

I'll give you an example. Let's say someone goes on a diet and you are used to eating fatty foods and steaks and this

and that, and you really enjoy ice cream, and you put someone on a restrictive diet, which is common for a lot of us. Diets are pretty common. You talk to family members and they will tell you, "Wow, stay away from her, stay away from him. He is irritable and he is antsy and he is not sleeping."

I don't know if I'd call them withdrawal symptoms. We can use that term. But the point is, if you are doing something repetitively, you're used to it, you like it, and then you are asked to stop it, it is not uncommon for people to develop changes in their mood. We can call it withdrawal symptoms or not, but the point is, it doesn't feel good. You miss what you were doing. So people have different reactions to that.

Q. Doctor, we had on the board here just a minute ago these various substance dependences. As a psychiatrist, when you treat people for their substance dependences, does the treatment vary depending upon what the substance is?

A. Oh, it varies tremendously. In common, you want to teach people behavioral ways to change their behavior. But the medications we use can vary. Of course, for the withdrawal symptoms I am going to have to hospitalize some people because of the dangerousness. For some types of disorders I really need to get people out of their environment so that they are not going to be exposed.

If you have a person who abuses crack cocaine, you

have to get them away from the environment where they could actually get a hold of that. Same thing for heroin too. You really need some time away from their ability to get that substance if you are going to be successful in your treatment.

Q. Doctor, how do you assist someone who indicates to you that they actually want to quit smoking as opposed to someone who tells you that no, they are not interested, they enjoy smoking, and they don't want to quit smoking? What do you do for somebody who comes to you and says, "Yes, I am prepared. I do want to quit smoking. I am ready to give up those pleasures that you talked about?"

A. Sure. If they want help, I'm certainly going to try to help them. Again, I try to individualize plans as much as possible.

Number one, I'm going to educate them. What are some of the benefits of them stopping smoking? In my clinical experience actually, as people know this already, they know the health risks of smoking cigarettes. But still, I'm going to re-educate them. Let me encourage them as much as possible to want to change. Again, usually they are already at that point, if I am going to be having this kind of conversation.

I am going to provide therapy. I am going to provide support. I am going to try to get family members, loved ones, significant others, to try to be part of what we're doing to help people stop.

THE COURT: Doctor, I am sorry to interrupt you. You

are talking now about you're going to provide therapy and support. Then you are going to go to family members and get them do that; is that right?
THE WITNESS: That's correct.
THE COURT: When you go to the next group, could you talk a little slower
MR. REILLY: Sorry, Your Honor.
THE COURT: He can't help it. It's a compulsion. He has got to talk to one of his colleagues about this one of these days.
MR. REILLY: If I could think that fast.
THE COURT: I'm sorry. It's just your normal way of speaking, and that's fine. We are trying to make a record here, and it's a little hard because you do speak rapidly. And we all comprehend what you are saying, but if you could slow it down, we can get a better record.
Where we left off, the question was, what do you do to help somebody that really wants to quit. You talked about educating them and going to your family. That's where I interrupted you.
THE WITNESS: I will certainly try to talk slower.
What I am going to do next is I am going to provide behavioral therapies. I am going to offer different ones. And to be honest, I am going to try to find one that fits that

person. Some of them we talked about. I am going to teach them some self-hypnosis techniques. I'm going to teach them some self-relaxation techniques. I'm going to try to get them motivated for some kind of physical exercise. If there is a local support group, I'm going to try to get them involved in that. People will not do all of these, but I am going to try to find the ones that people are willing to try.
Then I may also use some nicotine replacement therapies. What I usually do is a combination of Zyban, which is that anti-depressant that you prescribe that can reduce cravings in some people. In addition to that, I usually use the nasal inhaler, which is kind of the closest you can get to smoking a cigarette, in terms of getting nicotine in and levels decreasing. So I usually use a combination of those techniques.
BY MR. REILLY:
Q. Doctor, I would like to ask you one other thing, and then if it's appropriate, Your Honor, to break for the noon break.
If you have someone who is a heroin addict, what kind of treatment do you provide for them?
A. It's going to be very different. If someone is a heroin addict, I am going to need to hospitalize them, usually, to get them away from heroin because they are going to find a way of getting it if they're quote, addicted, or dependent on heroin.
I'm going to give them medications to block the

withdrawal. I am going to give them medications that bind to the same receptors as heroin does to reduce the withdrawal. And I am going to get them very involved in 12-step, NA, Narcotics Anonymous, therapies so that they have a lot of support, they have a kind of a game plan, a way of addressing their daily craving for heroin.
Q. A much different situation?
A. Much different in terms of the intensity, in terms of the kind of therapies you need to use. Very different.
MR. REILLY: Your Honor, this would be a good spot.

THE COURT: Ladies and gentlemen, we will take the noon recess at this time, and ask that you return this afternoon at 1:15, I guess, given our schedule. Later on we are going to let you go home early. We have got some matters we are going to take up. We will resume at 1:15 after the lunch recess. Thank you very much.

[The jury leaves, the courtroom.]

THE COURT: Doctor Kaplan, we are in the middle of your testimony, so we ask that you not discuss your testimony with any of the lawyers or staff people. Certainly, you can talk to them about where to go to lunch or whatever, but as far as your testimony and all of that, we ask that you not discuss that.

Maybe to help the doctor -- help do this a little bit slower, maybe you could pause after he finishes an answer

before you start with your next question. We don't need this on the record.

THE COURT: Thank you, gentlemen.

[Morning proceedings concluded at 12:15 p.m.]

C E R T I F I C A T E

I hereby certify that the foregoing is an accurate transcription of proceedings in the above-entitled matter.

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DATE

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